Eastgate Family Medicine, PLLC
Joy S. Stiefel, D.O.
www.eastgatefamilymedicine.com

# Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth_____

Previous name: _____

## I. My Authorization

I allow **Eastgate Family Medicine, PLLC** to share the below health care info (check all that apply):

- ☐ All health care info in my health record
- ☐ Health care info in my record about the below care or health issue:

  _____
- ☐ Health care info in my health record for the date(s):

  _____
- ☐ Other (e.g., X-rays, bills)—list date(s):

  _____

Uses and disclosures needing specific authorization:
You may use or share health care info about testing, diagnosis, and aid for (check all boxes that apply):

- ☐ HIV/AIDS, STDs
- ☐ Sexual orientation / Gender dysphoria
- ☐ Mental health
- ☐ Drug and/or alcohol abuse

You may share this health care information with my new physician:

_____
Name (or title) and group or class of persons (Please print)

_____
Address City State Zip

Reason(s) to use or share my health care info (check all that apply):

- ☐ At my request
- ☐ Dr. Stiefel's retirement



14100 SE 36th Street, Suite 115 Bellevue, Washington 98006 phone 425-644-3066 fax 425-644-3057

This authorization ends on (date): _____ **or** when the below event occurs:

_____

If an end date or event is not given above, this agreement ends six (6) months after the date signed.

## II. My Rights

1. I know that I do not have to sign this form to get health care benefits (aid, payment, enrollment, or eligibility for benefits). However, I do have to sign this form:
   - to get research-linked health care for research studies **or**
   - to get health care when the purpose is to craft health care info for a third party.
2. I may cancel this form in writing at any time. If I do, it will not change any actions taken by **Eastgate Family Medicine, PLLC** in reliance on this authorization before it receives my written revocation. I may not be able to revoke this agreement if its purpose was to obtain insurance. Two ways to revoke this agreement are:
   - Fill out a revocation form—a form is available from **Eastgate Family Medicine, PLLC** or
   - Write a letter to **Eastgate Family Medicine, PLLC**

## III. Protection after Disclosure

I know that once my health care info is disclosed, the person or group that receives it may re-disclose it and that privacy laws may no longer protect it.

_____

Signature of patient or legally approved person Date Time

_____

Printed name (if signed for the patient) Relationship (parent, legal guardian, personal representative)

_____

Description of personal representative's authority

_____

Minor patient's signature, if 12 years old or older Date Time



14100 SE 36th Street, Suite 115 Bellevue, Washington 98006 phone 425-644-3066 fax 425-644-3057